STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505280	A. BUILDING _____ B. WING _____	C 09/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENTON NURSING AND REHABILITATION CENTER	80 SOUTHWEST SECOND STREET RENTON, WA 98057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Renton Nursing and Rehabilitation Center conducted on 09/23/13. The sample of 18 residents was based on a census of 80. The following were complaints investigated as part of this survey: 2877246 The survey was conducted by: [redacted] MSN, RN Complaint Investigator The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388 Telephone: (253) 234-6039 Facsimile: (253) 395-5070 Mike Anberse 09/24/13 Residential Care Services Date	F 000	This plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Renton Nursing and Rehabilitation Center does not admit that the deficiency or deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency or deficiencies. The Center reserves the right to challenge in legal and / or regulatory or administrative proceedings the deficiency or deficiencies statements, facts and conclusions that form the basis for the deficiency or deficiencies. RECEIVED OCT 10 2013 DSHS/ADSA/RCS Region 4	10/9/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	administrator	10/9/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff transcribed a physician ordered test to rule out blood clots/bleeding in a timely manner. This failure placed, one of 17 residents (#1) reviewed for transcription of laboratory tests, at risk for developing undetected and untreated life threatening blood clots or bleeding and contributed to Resident #1's need for hospitalization. Findings include: Resident #1 was admitted to the facility with a history of a stroke, and end stage liver and kidney disease requiring dialysis and treatment with blood thinners [redacted], according to the 06/12/13 and 08/25/13 Minimum Data Sets. Staff assessed Resident #1 to require extensive assistance with activities of daily living from one or two staff. Resident #1, was observed lying in a low bed fitted with fall mats, on 09/23/2013 at 10:00 a.m., and had no complaints when interviewed. According to Resident #1's clinical records staff	F 309	F-309 1. Resident #1 was re-admitted to the facility on [redacted], 2013. 2. Residents in the facility on blood thinning agents were reviewed to ensure proper measures were in place and completed in accordance with physician orders. Review included residents on [redacted] and antibiotics. The Pharmacy Consultant review of residents was conducted with recommendations provided for administration and monitoring of [redacted] The Medical Director conducted a chart review with analysis and recommendations for prevention measures.	10/9/13

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F 309	Continued From page 2 followed physician orders and arranged for the laboratory to obtain a blood specimen that would measure how readily Resident #1's blood clotted until 08/26/13. On 08/26/2013, the physician's orders read "(increase) [redacted] to 7 mg (milligrams) po/day (by mouth/per day) Repeat PT, INR (tests to measure blood clotting) in 3 days". The dose of [redacted] was increased because the blood test for clotting indicated the medication was not at a therapeutic level in Resident #1's blood. Review of the Medication Administration Records (MAR) revealed Staff C, who was not available for interview, transcribed the first part of the physician's orders and documented they administered the first dose of [redacted] on 08/26/2013. The second part of the order was transcribed on the same MAR. The entry was checked off as if the order was completed and the blood was drawn. But, according to the facility's evidence of investigation Staff C told the DNS they made the check mark on the MAR, even though the test was not done. The facility documented, in the evidence of investigation, the physician was not notified the blood test was not done. According to the Director of Nursing (DNS) Staff B, interviewed on 09/23/2013 at 08:30 a.m., nursing staff were to complete a laboratory requisition and place the requisition in the laboratory book on the day the laboratory test was to be drawn. The DNS said Staff C did not follow this policy. As a result Resident #1's blood was not assessed for clotting ability until Resident #1 was noted to have a bowel movement that was black and expressed bright red blood from the rectum on 09/11/13. This was 16 days after the	F 309	F-309 continues: 3. Staff C's employment was terminated. Care Plans were reviewed and updated for residents on Coumadin therapy. PT / INR flow sheets were reviewed and updated, then placed in the MACC book for daily nurse manager review during the morning meeting. Licensed staff were re-educated to the procedure for processing physician orders for labs to include documentation on physician order and lab requisition form. Clinical staff were educated to monitor and report signs and symptoms of increased bruising and or bleeding, including the identification of melena and dark tarry stools.	10/9/13

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F 309	Continued From page 3 dose of [redacted] was increased and 13 days after the laboratory test should have been obtained. Resident #1 was hospitalized on 09/12/2013 for gastrointestinal bleeding.	F 309	F-309 continues: Finally, a review of facility guidelines for anti-coagulation therapy to identify gaps in the system and were updated for prevention of reoccurrence. 4. The Resident Care Managers will monitor for compliance through the MACC process during the morning clinical meeting. The Director of Nursing Services will ensure compliance through the MACC process during the morning clinical meeting.	10/9/13